

## Addressing Low Contraceptive Use in Rural Tanzania

By

Nora Kelly Barker

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***Second Reader Signature/printed name***

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## **Glossary**

ACU	Accelerating Contraceptive Use
ADDO	Accredited Drug Dispensing Outlets
CARE	Cooperative for Assistance and Relief Everywhere
CBD	Community-Based Distribution
CBRHP	Community Based Reproductive Health Plan
CCHP	Comprehensive Council Health Plan
CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women
CPR	Contraceptive Prevalency Rate
CTU	Contraceptive Technical Update
DMPA	Depot Medroxyprogesterone Acetate
FBO	Faith Based Organization
FWCW	Fourth World Conference on Women
GTZ	Deutsche Gesellschaft für Technische Zusammenarbeit (German Development Cooperation)
HCW	Health Care Worker
HEqG	Health Equity Group
ICPD	International Conference on Population and Development
IPPF	International Planned Parenthood Federation
IUCD	Intrauterine Contraceptive Device
LAM	Lactation Amenorrhea Method
LGA	Local Government Authority
MCH	Maternal Child Health
MDG	Millennium Development Goal
MMR	Maternal Mortality Rate
MoHSW	Ministry of Health and Social Welfare
NFPCIP	National Family Planning Costed Implementation Plan
NGO	Non Governmental Organization
O&OD	Opportunities and Obstacles to Development
One Plan	National Road Map Strategic Plan to Accelerate the Reduction of Maternal and Newborn Deaths in Tanzania
PEPFAR	President's Emergency Plan for AIDS Relief
PMO-RALG	Prime Minister's Officer for Regional and Local Government
PSI	Population Services International
RCHS	Reproductive and Child Health Services
SDM	Standard Days Method
TACARE	Tanganyika Catchment Reforestation and Education
TDHS	Tanzania Demographic and Health Survey
TRCHS	Tanzania Reproductive and Child Health Survey
UMATI	Tanzania Affiliate of IPPF
UNFPA	United Nations Population Fund
UNRISD	United Nations Research Institute for Social Development
USAID	United States Agency for International Development
WD	Women's Dignity

## Abstract

The maternal mortality ratio (MMR) for Tanzania is high at 578 deaths/100,000 live births and is in fact, getting worse (TDHS, 2004-5). By comparison, the rate in 2005 for developed countries was 9/100,000 live births. The fastest way to lower this high incidence of maternal deaths is through healthy timing and spacing of pregnancies by using modern methods of contraception. The rate of unmet need for family planning (spacing or limiting pregnancies) is 22% ~~throughout~~ for the country as a whole. Family sizes are larger and access to family planning services significantly lower in the rural areas (TDHS, 2004-5). The President of Tanzania is committed to lowering maternal mortality and the government of Tanzania realizes that in order to reach Millennium Development Goal 5, lowering maternal mortality, the high rate of unmet family planning needs ~~must~~ be addressed. In 2009 the goal was set to increase the contraceptive prevalence rate (CPR) from the current 26% to 60% by 2015. Since only 25% of the population lives in urban areas, contraception uptake will need to increase significantly in the rural areas. There are many reasons for low usage of family planning including poor access to care, lack of supplies, cost and widely held misconceptions about the risks of family planning versus pregnancy. These issues will have to be addressed in order to meet the goal of 60% coverage. The government has set out goals to be met at different levels from national to local. Non-governmental organizations (NGOs), Faith Based Organizations (FBOs) and other civic organizations are working with the government to try to achieve these goals. Some approaches used in Tanzania and other developing countries to increase contraceptive use include developing the capacity of district officials so that they budget enough for family planning needs,

working with religious leaders, training community health workers to give injections of DMPA (Depot Medroxyprogesterone Acetate, commonly known as Depo-Provera), and working with traditional healers. In this paper I will address some of the strategies and approaches that have been tried and proven successful in different areas of Tanzania and selected other developing countries. I argue that they should be adopted and promoted at the national level throughout Tanzania to increase the use of modern methods of contraception and to ultimately lower the maternal mortality ratio.

### **Introduction**

Official statistics for the Government of Tanzania place the Maternal Mortality Ratio (MMR) at a high 578/100,000 live births in 2004-5 (TDHS, 2004-5); estimates from the UNFPA State of the World Population Report 2008 place it at an even higher 950 deaths per 100,000 live births. In Tanzania one in 24 women will die from complications of pregnancy and childbirth (WHO, 2007). According to Huber (2010) “The fastest, easiest, cheapest way to prevent maternal deaths in Tanzania is with family planning – family planning is 100 times safer than pregnancy”<sup>1</sup> (Douglas Huber, PP presentation, slide 7, CTU 22/01/2010 Tanzania). The rates of contraceptive use in rural areas of Tanzania are still very low. While the argument is often made that if the child mortality rates go down fertility rates will also, this has not been well borne out in Tanzania where declines in total fertility rates<sup>1</sup> have not been nearly as dramatic as those in child mortality. Under five mortality rates have decreased from 162/100,000 live births in 1990 to 112/100,000 in 2004-the latest records. (Mortality Rates are much higher for children whose mothers are under 20 years of age as well as those whose birth order is number

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<sup>1</sup> Total fertility rate is defined as “the total number of births a woman would have by the end of her childbearing period if she were to pass through those years bearing children at the currently observed age-specific fertility rates. The TFR is obtained by summing the age-specific fertility rates and multiplying by five.” (One Plan)

seven or higher.) Total fertility rates have only decreased from 6.3 to 5.7 in the same time period and only down from 5.8 in 1996 (TDHS, 2004-5).

### **Data Regarding Contraceptive, Maternal and Reproductive Health**

According to the 2004-5 Tanzania Demographic and Health Survey (TDHS, 2004-5), in the rural areas 21% of women were using a method of contraception and only 15.5% were using a modern method<sup>2</sup>. This is about half of the rate of their urban counterparts for contraceptive use (41.8 % of urban women) and even less than half for a modern method (34.3% of urban women). “An average of 24 women dies every day in Tanzania in the process of child bearing” (UNRISD, 2008). UNFPA states “One in three deaths related to pregnancy and childbirth could be avoided if women who wanted effective contraception had access to it.”<sup>2</sup> Extrapolating from the above, modern contraceptive methods are more than 100 times safer than pregnancy in Tanzania.

In Tanzania ~~twenty-two (22%) percent~~ of currently married women have an unmet need for family planning. Unmet need is defined as “Women who say either that they do not want any more children or that they want to wait two or more years before having another child, but are not using contraception”. (TDHS, 2004-5). Throughout the whole country there is a 15 % unmet need for spacing and 7% for limiting. (p. 113). The unmet need for spacing and limiting pregnancies in urban areas is 10.2% and 6.3% respectively, compared with 16.6% and 6.8% in rural areas.” (p. 114). Since the publication of the 1999 Tanzania Reproductive and Child Health Survey (TRCHS) there has not been significant change in unmet need or demand for family planning services. Data is only reported for married women and women in unions but not for women who

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<sup>2</sup> female sterilization, pill, intrauterine contraceptive device (IUCD), injectables, implants, condoms and Lactation Amnorrhea Method (LAM) (TDHS, 2004-5)

are sexually active and not in permanent unions, leading to under reporting of unmet need and demand.

There has been a slight decline in the number of children considered to be the ideal. The following tables spell out what changes have been seen. (TDHS, p 120)

<b>Number of Children Considered the Ideal, Tanzania, by <u>Y</u>ear (TDHS 2004-5)</b>		
Year	Women	Men
1991	6.1	6.5
2004-5	5.0	5.3

<b>Ideal <u>N</u>umber of Children by <u>R</u>esidence, Tanzania, (TDHS 2004-5 and 1991)</b>		
Place of Residence	Women	Men
Urban 2004-5	4.0	3.9
Rural 2004-5	5.4	5.8
Urban 1991	5.4	N/A
Rural 1991	6.3	N/A

<b>Wanted Fertility Rates, Tanzania 2004-5 (TDHS 2004-5)</b>		
Place of residence	Total wanted fertility rates	Total actual fertility rates
Urban	3.1	3.6
Rural	5.6	6.5

Mass media (radio, television, newspaper, magazine, poster, and billboard) and community events such as live drama are being used to get family planning messages out. Rural women who are less likely to use a method also have the highest rates (42.6% vs. 13.6% for urban women) of not having seen or heard these messages. What is interesting is that only 18.3% of rural men report that they had not seen these family planning messages, so there is evidence that the messages are being disseminated. (TDHS, 2004-5, pp. 87-8).

The approval of men for their wives' use of contraceptives varies from urban to rural. In urban areas when the woman approves of their use, 11.5% of their husbands do not. In rural areas when the woman approves of the use of contraceptives 17.3% of their husbands do not (TDHS, 2004-5, p. 96).

### **Demographics**

In 2005 the population of Tanzania was estimated to be 39,204,000 (Catholic Hierarchy, 2005) quadrupling what it was at independence in 1961: 9.4 million (Nelson). With the current annual growth rate of 2.9% (One Plan) it will double in 24 years. Only 25% of Tanzanians live in urban areas (Theodora.com). About 40-45% of the population is Christian, about 35-40% is Muslim and the rest of the population follows traditional beliefs (Tanzania Tourist Board). According to the Catholic Hierarchy 26.69% of the population is Catholic (Catholic Hierarchy). 47 percent of the population is under age 15.

The Tanzania: Population, Reproductive Health and Development report of 2006 provides charts comparing projected population and needs if the country continues with high fertility versus if the country can achieve lower fertility. With continued high fertility

the population is expected to reach 86.6 million in 2035 but with lower fertility it will reach 66 million. Population at present is around 42 million. In that same time period these trends will produce 16 million primary school children needing 40,000 primary schools if rates stay high or 10.1 million primary school children needing only 25,300 schools with lower fertility. Lower fertility rates will save 2.3 trillion Tanzanian Schillings (approximately 1.7 billion US dollars at today's rate) in just primary education alone. The cumulative savings in health care would be 2.2 billion US dollars in the same time period.

Gallagher (2009) tells us that the Catholic Church prohibits “artificial” forms of birth control such as oral contraceptive, IUCDs and sterilization. Very few health care workers in Tanzania are proficient at teaching fertility awareness methods that are acceptable to the Catholic Church.

### **Goal for Tanzania Reproductive Health**

In order to meet Millennium Goal number 5 which is to improve maternal health, Tanzania has set a very high target to increase the Contraceptive Prevalence Rate (CPR). The National Road Map Strategic Plan to Accelerate Reduction of Maternal, Newborn and Child Deaths in Tanzania 2008 – 2015 (also called the “One Plan”) sets the target of increasing the CPR rate to 60 percent by 2015. The current rate is 26.4% for married women and 40.5% for sexually active, unmarried women (TDHS, p. 74). This goal is to be achieved by “making family planning services more accessible to all Tanzanians” (One Plan). According to the Comprehensive Council Health Plan (CCHP) guideline, family planning is in priority area number one which is “Reproductive and Child Health Promotion and Care” (p. 7).



In March, 2009 the government of Tanzania began to develop a National Family Planning Costed Implementation Plan (NFPCIP) for a 'repositioned' national family planning program. This plan defined six strategic action areas that must be addressed to successfully increase family planning.

These are

- “Focusing on advocacy and generating demand for family planning. This includes ensuring that policies support family planning. Community members must also become aware of the value of family planning.
- Strengthening Management Systems,
- Monitoring and Evaluation,
- Ensuring Contraceptive Security and Logistics,
- Building capacity of those involved in family planning services; and
- Strengthened Service Delivery Systems so that family planning services are of high quality, affordable and can be sustained over a long time.” (P. 6 )

The NFPCIP was developed at the national level and is to be used to help district officials develop their capacities in planning budgets for family planning activities. It will provide officials with information about key family planning activities, input required and costs. (One plan)

### **Obstacles to Expanded Family Planning**

Many problems have been encountered in providing family planning services throughout Tanzania but especially in the rural areas.

**Cost Factors:** Cost is a major concern both at the government level and for clients themselves. Maternal/Child (MCH) health services are supposed to be free but

are often not. Informal charges (such as paying for delivery kits, medications, fees for doctors and nurses, etc.) are common and are a deterrent to seeking care. A recent study found that, “the formal charges at hospitals were said to be out of reach for some members of the community” (Kaharuza, 2001, p. 12).

In order to increase the CPR to 60 % by 2015 the Costed Implementation Plan projects the cost to be \$91,000,000 for the years 2010 to 2015. While this seems enormous the costs of not reaching this goal is even larger. In lowering the fertility rate by the year 2035, the cumulative savings in health care alone would be 2.2 billion US dollars- more than double the cost of the CIP.

The government of Tanzania has not been consistent in mobilizing funds for procuring contraceptives. It increased from 1.5 billion Tanzania Schillings (TSh) in 2002/2003 to a high of 7.7 billion TSh in 2004/2005. It was down to 5.8 billion TSh in 2006/2007 (Reproductive Health and Development, 2006).

Government officials at lower levels are not aware of their budgets. Minha (as cited in Kovsted, 2007) states that the allocation of government resources is “shrouded in ambiguity and central government domination” and at central government levels allocation are “determined in an ad hoc fiscal fashion”. Communities do not participate in planning and financial management of health so they also are not aware of budgets (URT 2005d).

**Supplies of Contraceptives:** Contraceptive supplies and equipment are often not available in stock when clients come for services. The method range may be limited without a method that is appropriate or acceptable to the client (Acquire final report).

**Access to Care:** Limited access to health facilities makes family planning use difficult to obtain. Physical access is a problem with 11% of rural households (approximately 3.5 million people) being more than 10 kilometres (6 miles) from the nearest primary care facility (TDHS, 2004-5). Because rural roads are usually poor, these health facilities can be difficult to reach, especially in the rainy seasons (Kaharuza, 2001). Even for women who live close to health care facilities, if supplies and staff are not available they are still unable to access services.

**Staffing Needs:** Existing health facilities are severely understaffed. “Only 30-40% of key health care staffing requirements are presently met and the situation is worse in health centers and dispensaries which serve the majority of the poor. The gap is also large between urban and rural areas” (TGNP, 2005/06). This probably reflects the low wages paid to health care workers as well as other amenities missing in rural areas such as staff housing and good schools for children of the staff.

**Misconceptions about Contraception:** Misconceptions about contraceptives are widely held in Tanzania. Many people think that they will become ill or weak or have changes in sexual performance if they were to use contraceptives (Kaharuza, 2001). Some think that contraceptives are riskier than pregnancy (Barker, P. personal communication, January 10, 2010). These misconceptions are not just among potential clients but also among people who influence their decisions including health care providers, teachers and religious and community leaders (National Package of Essential Family Planning Interventions for the Comprehensive Council Health Plan).

**Gender Issues:** Because of the low social and educational status of women in Tanzania, many are still unable to make their own decisions about how many children

they should have and whether or not to use family planning (National Population Policy, 2006). In a survey for the 2005 TDHS “Only 11 percent of men think a wife should have a say in all specified decisions, and 10 percent of men think that a wife should have a say in none”.

**Donor Commitment:** There has also been a lack of clarity from one major donor (Harris, p 3). Under the US administrations of George H.W. Bush and George W. Bush nongovernmental organizations were not able to program any funds, private or federal to the support of legal, safe abortion if they received US funding (commonly called the Mexico City policy). Some organizations such as Marie Stopes and the IPPF affiliate Umati were not able or willing to follow this rule and thus lost that funding. This was rescinded in January 1993 by President Clinton and again in January 2009 by the Obama administration but could again be reversed by future US Presidents (Huffington Post, 2009/01/23).

**Lack of Community Participation:** Programs are often initiated and implemented without community participation in planning and implementation, leading to a lack of “community ownership.” Without community ownership programs probably will not succeed (Harris). Another problem may come if the programs for implementing family planning are vertical and not integrated into the normal health system (Harris, 2004, p.3).

**Beliefs:** A large percentage of the population is Roman Catholic. Gallagher (2009) tells us that the Catholic Church prohibits “artificial” forms of birth control such as oral contraceptive, IUCDs and sterilization. Very few health care workers are proficient at teaching fertility awareness methods that are acceptable to Catholics.

While rates of family planning are low, there is evidence it is a felt need in at least some rural areas of Tanzania. Robinson (2007) tells of surveys taken by CARE International in Tanzania where CARE staff facilitated dialogue with 36 village groups (6 groups in each of 6 villages) to help them agree on their first priority in addressing Maternal Newborn Care (MCH). The groups were homogeneous, one composed of village leaders, one of village resource people, one of men aged 21 years and older, one of women aged 21 years and older, one of men younger than 21 years and one of women younger than 21 years. In 24 of the 36 groups participants mentioned family planning as the key entry point for action in improving MCH (Kaharuza, 2001, p. 23-4). One other problem is health care workers who think that women want to have many babies. My own interviews with midwives found that many say that the women in rural areas want to have many babies. Yet, when I asked the midwives if the women told them that, they gave me no answers.

### **What is ~~B~~being Done to Increase Contraceptive Use**

The government and other organizations working in both Tanzania and other developing countries have found ways to address some of the problems seen as hindering contraceptive use in Tanzania.

**Government of Tanzania Policies and Initiatives:** The government of Tanzania has developed several plans for accelerating family planning throughout the country. The Ministry of Health and Social Welfare approved The National Road Map Strategic Plan to Accelerate the Reduction of Maternal and Newborn Deaths in Tanzania (2006-2010) (One Plan). This plan recognizes the importance of family planning. The Ministry made the decision to increase contraceptive prevalence rates (CPR) to 60% to meet

Millennium Development Goal number 5. The ministry also developed and approved the Reproductive and Child Health Strategy – 2005-2010 which puts family planning into priority area number one.

Council Comprehensive Health Planning Guidelines have been developed for use in district areas to help officials plan budgets for health care at the local level and this guidance includes family planning budgeting.

The government of Tanzania realized the need for planning for health care at many levels. The National Framework on Participatory Planning and Budgeting was developed to empower people at community levels to develop and implement their own plans rather than receiving plans from outside sources. The government realized that there would be many methods used to achieve participatory planning, so they developed the Opportunities and Obstacles to Development (O&OD) Planning Guidelines to help facilitate a bottom-up approach to planning and to harmonize the different approaches. These guidelines will try to help planners deal with some of the problems they might face.

Tanzania is also committed to the rights of women. It has signed the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), the 1994 Cairo International Conference on Population and Development (ICPD) Programme of Action and the 1995 Beijing Declaration and Platform of Action of the Fourth World Conference on Women (FWCW) (UNFPA).

The government has been decentralizing health services since 1983 (World Bank, 1999). Hutchinson (2002) found that while family planning was only fourth on the list of most important health areas that should receive budgets, in districts where health

care planning had been decentralized almost 90 percent of District Health Management Teams reported that family planning was receiving greater attention.

**Advocacy:** Advocacy has been seen as one way to improve family planning. Organizations are partnering with the government to advocate for reproductive health issues. The Health Equity Group (HEqG) (made up of Women's Dignity, Youth Action Volunteers, the *Tanzania* Gender Networking Programme, and CARE International) is working with the Prime Minister's Officer for Regional and Local Government (PMO-RALG), which is responsible for producing the Village and Local Government Authority (LGA) planning guidelines for all sectors, and over-seeing the approval of plans and budgets. As part of its work with the PMO-RALG, the HEqG helped local stakeholders in Mwanza hold the decision makers accountable for developing plans that would have a positive impact and for developing budgets that provide for health care (CARE 2009).

Women's Dignity employs a tripartite dialogue where all parties involved in health care at the local level, including clients, come together to talk about accountability and transparency for health care. This also allows health care workers to explain why they may not be able to provide all the services that are expected. Women's Dignity has also engaged communities in Popular Tribunals so that there is accountability for women's rights, especially in health issues. Case studies are brought up in the tribunal and legal advice is provided together with mock rulings. Popular tribunals have been successful in highlighting denial of women's rights to the judiciary and policy makers (WD annual reports for 2007 and 2008).

Anne Barrington, the Irish ambassador to Tanzania, has also advocated for health care. To celebrate Ireland's National Day (March 17, 2009) she called on

development organizations to coordinate money for health care. A large amount is spent on HIV/AIDS but the amount spent on MCH issues is not proportional (Guardian, 19 March 2009).

EngenderHealth (through the Acquire project) has several programs which include helping build the capacity of local health officials to advocate for family planning resources and programs. They also believe that advocacy is an important part of family planning/reproductive health because it is not just a health issue; it is also socio-cultural, economic and political.

Community-based Distribution (CBD) workers also advocate for family planning. They have helped in promoting Long Term/Permanent Methods (LTPMs) of contraception by referring clients to providers of those services. Marie Stopes found that approximately 80% of their referrals for sterilization come from their volunteer CBD workers (Harris, 2004).

The government of Iran realized that it could not sustain the growth rate that it had reached in the early 1980s so advocated for a nation-wide program to promote family planning. The program had three major goals: to postpone the first pregnancy, to increase birth spacing and to limit family size to three children. The country saw dramatic decreases in fertility rates, from over 6 children per woman in the mid-1980s to 2.1 in 2000. Rural fertility fell from 8.4 births per woman in 1985 to 2.4 in 2002. Contraceptive Prevalence Rate increased from about 20% in 1970s to 67% in 2000.

**Addressing Costs:** In addressing costs to the client several organizations have found that using Community-based Distribution (CBD) workers to provide contraceptive supplies not only makes the supplies available closer to home and more likely to be



accessed, it also saves the client costs such as time spent away from work and cost of transport to distant sites (Hashemi 2009). In the USAID report of their CBD funded projects they recommend cost sharing by the community to pay for the worker's services. This payment can take the form of nonmonetary incentives such as food items.

In order to achieve the Tanzanian government's goal to increase the CPR to 60% the Costed Implementation Plan was developed. When the Management Team of the MOHSW met on 23 December 2009 to discuss the NFPCIP and the first general comment was that the cost was too high (Minutes of meeting). While it is true that it is extremely expensive to provide all the resources necessary to meet this budget the cost of not funding it is significantly greater in terms of providing for those extra children and the higher maternal mortality rates. While the central government does not have adequate funds at present, they have pledged to try and obtain resources in partnership with domestic partners and international donors (MDG Progress report, 2000-2008).

**Ensuring Adequate Supplies of Contraceptives:** While lack of supplies is still a problem, several organizations are trying to address this. The ACQUIRE project developed Reality  $\sqrt{}$ , which is a model to forecast contraceptive prevalence and to make it possible to realistically project contraceptive needs (The Acquire program webpage). John Snow International (JSI) implements DELIVER, a supply chain management project, which helps developing countries improve logistics systems for various family planning products (as well as other public health items) (PEPFAR). UMATI advocated for continuous supplies of contraceptives in the local English language paper, the Guardian (7/15/2009). The Accelerating Contraceptive Use project in Afghanistan

assured that the community health workers in their project areas had an abundant supply of contraceptive methods. In Iran the government realized the savings they would make by decreasing fertility and provided contraceptives free.

**Addressing Geographical Limitations:** Organizations have come up with different ways to address geographical limitations to accessing contraceptives. Some organizations are trying using task-shifting: training HCWs (Health Care Workers) and CBD workers in the villages to provide more methods of contraception so that women do not have to travel so far for care. In Tanzania the most popular form of contraception is the DMPA injection (20.1%) with the pill at 19.0%. When HCWs are allowed to give this injection, the CPR has been shown to increase. In the Afghan ACU project, Health Care Workers were allowed to give the first injection (where previously they were only allowed to give the second and following doses). Where this change along with other measures was introduced contraceptive prevalence rates increased by 24% in one area of Afghanistan and 27% in another area in just eight months. Family Health International (FHI) and Save the Children have utilized this method in Uganda where they were able to increase the CPR by 5% in the villages they served. Some organizations including GTZ (a German government branch for international aid) have used a CBD system of distribution of health care in rural areas of Tanzania. They have found this to be an effective way to provide health care including contraceptives in rural areas; however, they are not allowed to give DMPA. The vital role of CBD systems is further underscored by the experience of Iran where they saw a dramatic increase in CPR and a decrease in fertility rates.

Iran was able to address geographical limitation by integrating family planning services into the rural health program which was already in place. They had trained health workers from the villages themselves who were already providing health care services especially care of women and children. When the family planning program began in earnest, they already had trusted people in place to add on family planning services.

Marie Stopes, in its CHOICE program, takes teams in fully equipped vehicles to Ministry of Health posts in rural areas and offers free long acting and permanent methods (LAPM) thus assuring coverage in those areas.

**Addressing Staffing Needs:** To meet staffing needs the government of Tanzania has pledged to step up training, recruitment, and retention of medical personnel (MDG Progress report 2000-2008). In areas where health care workers are in short supply task-shifting has been used. Community members have been trained as CBD workers and community health workers providing health care as well as supplying contraceptives including DMPA injections. Another way to address staffing needs is through programs like Marie Stopes' CHOICE program which provides mobile services for LAPM in rural areas. In 2006, Marie Stopes Tanzania operated 19 mobile clinics and reached more than 600 sites.

**Addressing Misconceptions:** Several approaches have been used to address misconceptions about contraceptives. Women's Dignity (an indigenous Tanzanian NGO) has used various sensitization and training methods in rural areas. They have held meetings in villages to discuss health issues. They have shown a Swahili version of the BBC video "Dead Mum's Don't Cry" to open up the discussion about health services in

the villages and the health of women. They have also presented information through radio and television. (Women's Dignity Website)

The ACU project in Afghanistan held in-depth discussions with community leaders both men and women about family planning. They also provided short written information to clients using oral and injectable contraceptives which included side effects and when to expect a return to fertility. Clients were able to refer to this information when they had questions and they were aware of what to expect and to know what was normal.

**Community Participation:** Several projects have worked to involve men in reproductive health and to try and change the patriarchal attitudes often encountered. In CARE's CBRH project couples' communication regarding reproductive health was assessed to develop strategies to involve men and their role in important reproductive health decisions.

PSI in Democratic Republic of Congo set up a phone line where citizens could call in for family planning information on a toll-free number. They found that 80% of the callers were male. EngenderHealth has a "Men as Partners" program which works with men to help them promote gender equity and health in their families and communities. This program helps confront harmful male stereotypes and has local and national media events to promote partnership. It also works with health care facilities to offer better health care for men.

To address lack of community participation, organizations implementing community-based distribution have found their work to be effective when they set up

local partnerships (between communities and district governments, churches and communities, etc.).

Buy-in from religious leaders such as mullahs and priests has been shown to increase contraceptive use in villages. Dialogue with mullahs was integrated in the ACU program in Afghanistan. The project used quotations from the Quran about birth spacing. Each contraceptive method had a verse from the Quran approved by the mullah that advocated two years of breast feeding/birth spacing (Chapter 2, Verse 233 and Chapter 31, verse 14, Chapter 60, verse 12). Through this dialogue, all 37 mullahs in the project area accepted the concept of birth spacing using modern methods and used their Friday sermons to emphasize the importance of birth spacing. The backing of the clergy at the highest levels was also a critical aspect of the successful FP strategy used in Iran (Hashemi, 2009).

In the Lake Tanganyika Catchment Reforestation and Education (TACARE) project in western Tanzania, community members selected by peers disseminate family planning information and resources as well as environmental health interventions such as water and sanitation (TACARE). In the ACU project women in the community supervised the CHWs and created women's community health committees.

In another study in Kiboga, Uganda, traditional healers were taught about HIV/AIDS prevention and family planning. While the number of women surveyed after the training who had used the services of a traditional healer was small (44), the number of women using contraception increased from 8 before the training (18%) to 13 (29.5%) after. The number of women who were able to mention contraceptive methods increased also (Ssali, 2004).

**Integration into the National Health System:** To integrate family planning into the national health system the ACU project made sure that information from the project was disseminated in collaboration with the Ministry of Public Health so that the methods they used were advocated throughout the country. Women's Dignity shares their experiences of working with policy makers, activists and health care professionals through formal policy channels so change can be monitored. (WD Website)

**Providing Education:** An approach that Iran used when it became serious about decreasing the fertility rates was to require pre-marital counseling in order to register for marriage. This included information about contraception for both men and women. This requirement is still being implemented. Education about population was also integrated into the educational system at all levels (UNFPA).

Another important initiative is the education of females. When girls remain in school they marry later. As educational levels increase, there is also a decrease in what is perceived as the ideal number of children (TDHS 2004-5). Primary education in Tanzania is free (although parents are required to pay for uniforms) but there is a charge for secondary education. Iran was able to increase CPR because of the high rates of educated females.

### **What Else Can Be Done In Tanzania?**

Much more will have to be done throughout Tanzania at all levels to increase the CPR to 60%.

**Using More Advocacy:** The government of Tanzania's "Plans from Family Planning Interventions for Comprehensive Council Health Plan" (FP for CCHP draft) has tasked districts with:

“establishing a district family planning advocacy committee, organizing advocacy meetings with government officials, distributing policies and policy guidelines, and other family planning materials, participating in events to raise awareness of family planning, lobbying with the private sector to support FP, lobbying with MOHSW to allow districts to procure contraceptives through private sector to address short-term shortages, and advocating for Accredited Drug Dispensing Outlets (ADDOs) and pharmacies to carry injectables and pills.” (FP for CCHP)

**Providing Information about Family Planning Differently:** The FP for CCHP has tasked communities with “providing information, education, communication (IEC) in non-conventional sites” such as bars and barber shops, “using traditional cultural groups to disseminate family planning messages, providing testimonies on the benefits of family planning and identifying and orienting peer educators of family planning.” Using the media more often is effective at getting messages out to the rural areas. Sixty-two per cent62% of women and 80% of men listen to the radio, the most common type of mass media in Tanzania (TDHS). The more types of media that women are exposed to, the more likely they are to practice contraception (Jato, 1999).

Another use of the media is to present radio dramas about issues to be addressed. The Population Media Center presented broadcasts about family planning in 15 countries including Ethiopia. The broadcasts began there in 2002 and two years later the demand for contraceptives had increased 157%. Sixty-three per cent63% of new clients surveyed in 48 service centers coming for reproductive health care had listened to one of the radio dramas.

Involve youth in advocating for contraceptive use. Levers (2005) tells of Wilson Ngoni, a young artist and musician in Botswana, who has received attention for his painting on HIV/AIDS and his music about passion killings. He is very popular with the youth of Botswana. Utilizing the skills of young people who resonate with other youth is a successful way to spread messages.

Cell phones can be valuable in disseminating family planning messages. Cell phones are available and affordable throughout the country and are more popular than land lines. Ringheim tells of a program being tested in India for “Standard Days methods with phone call alerts.” Users of the method receive an SMS message reminding them of their fertile periods and when they should abstain from intercourse or use another method. Similar programs can be developed for use in Tanzania. Another suggestion is to ask the woman to set an alarm on her phone reminding her when she next needs contraception, such as DMPA (Sexuality and U). PSI’s program in DRC shows that people are anxious for family planning information and will call for information through a toll-free system linked to a trained educator.

Involving religious leaders has been found to be effective in encouraging family planning in Iran and Afghanistan. Verses from the Quran and Bible and other religious books can be used which highlight responsibility for family, health, environment, etc.

According to Kaharuza (2001), “the first provider of health care actually used in most areas (of Tanzania) is the traditional healer.” Including this type of health care provider in family planning has been used successfully in Uganda to increase contraceptive use.



**Utilizing Task-Shifting:** Allowing CBD workers and CHWs to give DMPA has proven to be a successful initiative in Afghanistan and Uganda. Unfortunately, it is not in the new National Package of Essential Family Planning Interventions for the Comprehensive Council Health Plan. A USAID report on CDB services found that once established and functioning, most CBD workers can accomplish (and usually desire to) additional health activities. CBD workers can also play an important role in referral for LAPMs.

While writing this paper the MoHSW held a workshop, which I attended, to finalize the family planning curriculum for long acting methods, IUD and implants. After discussion about which cadre of health care workers should be allowed to offer long term methods the ministry officials, under the leadership of Maurice Hiza, the family planning coordinator, approved allowing MCH aides to insert implants and IUCDs. MCH aides have one and a half years of training after leaving school. The older MCH aides had only a primary school education before the training; the younger ones have completed secondary school. By allowing MCH aides to give long term methods these services can be provided in more distant health centers as all dispensaries (the lowest level of health facility) are required to have an MCH Aide (not all dispensaries do have this cadre of provider, especially in the rural areas). (Hiza, M., personal communication, February 20, 2010).

**Providing Education about Family Planning Methods:** Health care workers can offer and promote alternative contraceptive methods that are acceptable to religious groups, including “Fertility Awareness” methods. These include(among others) the “Standard Days Method” (SDM) which helps a woman know the days when she is fertile

so that she can either abstain from intercourse or use another method of contraception such as the condom and the Lactational Amenorrhea Method (LAM). LAM is based on exclusive breast feeding for the first six months of the baby's life, frequent feeding including night time nursing and lack of menstruation for the method to be used successfully.

Health care workers need to offer family planning services whenever the woman comes to the clinic, i.e. when she comes with her child for vaccinations or illnesses. They also should ensure that women are offered a method before leaving the health care facility after delivery. Before providing a contraceptive method, the HCW must educate the woman on side effects she might experience. They can then address side effects before they happen, for example, by providing the woman with pain relief for expected cramps after IUCD insertion.

**Including Males:** Males can be engaged by reaching out to them through their “clubs” where they socialize and often work together on fund raising projects. They can also be reached through phones. PSI's program in DRC using cell phones was very popular with males so that might be another place to reach them in Tanzania also. More programs such as Men as Partners can educate men on reproductive health and their rights and responsibilities in family planning.

**Involving Non-Traditional Groups:** Because a larger population creates a greater need for resources such as water, trees, and agriculture, involving environmental groups to advocate for smaller families might have a positive impact. The government of Tanzania realizes this and has as one of its principles of the National Population Policy “thrifty exploitation of the country's non-renewable resources taking

into consideration the needs of future generations and sustainable development". The Jane Goodall Institute has a program in western Tanzania, the Lake Tanganyika Catchment Reforestation and Education (TACARE) project, which integrates preserving the biodiversity of the environment while providing for the health needs (including family planning) of the people living in the area of the Gombe Stream Chimpanzee Reserve. WWF has implemented programs in neighboring Kenya and in Madagascar integrating family planning into their environmental programs with good results.

**Supporting Girls' Education:** While primary education is now free, fees for secondary education must also be eliminated. Girls who get pregnant must be allowed to return to school after delivery. Schools must be designed or upgraded to be "girl friendly" including having enough latrines. To really push for higher quality of life for all we need make sure that all children pass secondary level in school.

### **Conclusion**

While the government of Tanzania acknowledges the low contraceptive prevalence rate in rural areas of the country, actions in the past have not been shown to increase the uptake dramatically. If the government is to reach the goal of 60% CPR by 2015, drastic changes will have to take place.

The MoHSW must comply with the Abuja Target of 15% of the budget spent on health care. The RCHS must assure that district health committees budget for family planning. The ministry is addressing this by providing workshops on the Council Comprehensive Health Planning Guidelines which train in budgeting.

The Tanzanian government will have to approve the Costed Implementation Plan. This plan was prepared by those with knowledge about implementing a successful family planning program and they have spent many months working to develop it.

The RCHS will have to convince the national government and international donors to support family planning in an adequate and ongoing manner. They will have this opportunity in March 2010 when they meet with donors in Washington, D.C. (Hiza).

The RCHS will have to change its policy on task shifting in order to provide more contraceptives in the rural areas. They have begun this by allowing MCH aides to insert implants and IUCDs. If they can be convinced to train CBD workers and HCWs in villages to give DMPA more women will probably use this method.

The government must drop fees for secondary school and increase the quality of education at all levels to keep students engaged and learning. When primary education became free many more children started to attend. Schools that are available need to be girl friendly including having separate latrines for girls and allowing girls to return to school if they have a baby.

The RCHS needs to ensure that health care providers receive training in all methods of FP including those acceptable to the Catholic Church such as the Standards Day Method. HCWs need to be proactive in offering contraception. Women will be satisfied with methods if HCWs advise them on side effects they may encounter and provide them with treatment before they have problems. There will soon be a new family planning curriculum. These recommendations are mentioned in the curriculum so those being trained will be exposed to them.

NGOs and FBOs can take lessons from what has been shown to work in other parts of Tanzania as well as other developing countries. Involvement of religious leaders has proven successful in several reports. Using the media, especially the radio, for messages is very effective for reaching rural areas. Community engagement including males is more effective in providing successful programs. Since many people visit traditional healers, the healers too should be educated about modern family planning methods. Environmental groups can add a family planning segment or partner with a group doing that.

There are several leadership steps that should be taken initially to increase CPR. NGOs, FBOs and politicians must advocate for the MoHSW to approve the Costed Implementation Plan. If the ministry is reluctant, the writers of the plan should provide them with estimates of what it will cost if they don't increase CPR.

Organizations and individuals working in rural communities need to empower community leaders to demand their rights. This includes access to quality health care and education.

The RCHS must ensure that comprehensive family planning training is given for all levels of HCWs so that there is more access to contraceptives in rural areas. The RCHS must also require HCWs to offer contraceptives.

With political will, determination and partnership with engaged communities Tanzanian women can take the lead in exercising and enjoying their reproductive rights, planning their families and improving their health and the health of their families. Important lessons can be adapted from successful FP programs in other countries as well as a wide range of successful, if currently limited, FP initiatives in Tanzania.

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